TENNESSEE BOARD OF OSTEOPATHIC EXAMINATION
665 Mainstream Drive
Nashville, TN 37243
(800) 778-4123, ext. 532-4384 Or (615) 532-3202, ext. 532-4384
www.tn.gov/health

APPLICATION FOR A SPECIAL TRAINING LICENSE AS AN OSTEOPATHIC PHYSICIAN

APPLICANT: Provide the information required in the Personal and Competency Information portions of this application, sign, have the affidavit notarized, and then submit the entire application to the appropriate training program personnel. The sponsoring institution must submit this application simultaneously with all required documentation. It is vitally important that you provide the required documentation to the program personnel as early as possible. Complete and submit along with your application the Practitioner Profile Questionnaire which is online at http://tn.gov/assets/entities/health/attachments/PH-3585.pdf. You are required by law update your profile within 30 days of any change as long as you have an active license. Failure to do so may subject you to disciplinary action. A criminal background check is required. For instructions to obtain a criminal background check, go to http://tn.gov/health/article/CBC-instructions. A Declaration of Citizenship must be completed before licensure can be awarded, go to https://www.tn.gov/content/dam/tn/health/healthprofboards/PH-41833.pdf.

Applicant's Name: ____
(First) *(Middle and/or Maiden)* *Last*

Have you been known by any other name? Y N If yes, list name: ____________________

Date of Birth: ____________________ Social Security Number: ______-_____-______
(Month) (Day) (Year)

Are you a U.S. Citizen? Y N Are you entitled to Live and Work in the U.S.? Y N

Are you a member of the U.S. armed forces who has, within the preceding 180 days, retired from the armed forces, received any discharge other than a dishonorable discharge from the armed forces, or been released from active duty to a reserve component of the armed forces? Y N (If yes, please provide proof of status.)

Are you the spouse of a member of the armed forces who has been transferred by the military to Tennessee or who has, within the preceding 180 days, retired from the armed forces, received a discharge other than a dishonorable discharge from the armed forces or been released from active duty to a reserve component? Y N (If yes, please provide proof of same.)

Present Home Mailing Address: ________________________________
____
____

Home Phone: ( ) ________ - ________

Residency or Fellowship Institution's Address: ________________________________
____
____

Work Phone: ( ) ________ - ________

Email address: ____

Do you wish to receive notification, including renewal notification, from the Department of Health via email? Y N

COMPETENCY INFORMATION

For the purposes of the questions below, the following phrases or words have the following meanings:

1. "**Ability to practice your profession**" is to be construed to include all of the following:

   a. The cognitive capacity to make appropriate clinical diagnoses, exercise reasoned medical judgments, to learn, and keep abreast of medical developments;
   b. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
   c. The physical capability to perform professional tasks and procedures required of your profession, with or without the use of aids or devices, such as corrective lenses or hearing aids.

2. "**Medical Condition**" includes physiological, mental or psychological conditions including, but not limited to: orthopedic, visual, speech and/or hearing impairments, emotional or mental illness, specific learning disabilities, drug addiction, and alcoholism.

3. "**Minor Traffic Offense**" generally means moving and non-moving violations punishable by fines only and does not include offenses such as driving under the influence or while intoxicated or reckless driving.

4. "**Chemical substances**" is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

5. "Currently" does not mean on the day of or even in the weeks or months preceding the completion of the application; rather, it means within the past two years or recently enough so that the use of drugs or alcohol or other medical conditions may have an ongoing impact on one's functioning as a physician.

6. "**Illegal use of illicit or controlled substances**" means the use of substances obtained illegally (e.g., heroin or cocaine) as well as the use of controlled substances that are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

Please respond to ALL questions. If you answer "YES" to any question, please attach a written explanation. Affirmative response requires final documents or orders from the issuing states, courts and/or agencies.

QUESTIONS:	**YES**	**NO**
1. The Board recognizes that licensees may suffer from potentially impairing health conditions, just like their patients, including psychiatric illnesses, physical illnesses which may impact cognition, and substance use disorders. The Board expects its licensees to properly address their health concerns, in order to ensure patient safety. Licensees should seek appropriate medical care and should limit their medical practice, when appropriate. The Board encourages licensees to utilize the services of the Tennessee Medical Foundation, a confidential resource which provides advocacy for licensees who may suffer from potentially impairing illnesses. (www.e-tmf.org)The failure of a licensee to adequately address any health condition which may impair their ability to practice medicine with reasonable skill and safety to patients, may result in the board taking action against the license to practice medicine. I have read and understand this statement.	____	____
2. Do you currently have any condition that is causing impairment that affects your ability to practice medicine with reasonable skill and safety in a competent, ethical and professional manner? *(You may answer no if you are being appropriately treated and are not impaired.)*	____	____

COMPETENCY INFORMATION
CONTINUED

		YES	NO
3.	Do you currently use any medications or substances (legal, OTC, prescribed or illicit) which in any way impairs or limits your ability to practice medicine with reasonable skill and safety in a competent, ethical and professional manner? If so, please list:______________________	____	____
4.	During the past two years, did you engage in any activity involving substances, either alcohol or controlled/illicit drugs, that impaired or limited your ability to practice medicine with reasonable skill and safety in a competent, ethical and professional manner? You may answer “NO” if you are being appropriately treated and are not impaired). It should be noted, however, that if such activity is not revealed, but manifests at some later time in your career, the Board, in its role as the protector of the health, safety and welfare of people in the State of Tennessee, will be able to pursue a disciplinary action on your license.	____	____
5.	Have you ever been diagnosed as having or have you ever been treated for a paraphilia or other type disease of a predatory nature such as, but not limited to pedophilia, exhibitionism, voyeurism, etc.	____	____
6.	Have you ever held or applied for a license or certificate in any state, country, or province, in any health care profession, that has been or was ever denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	____	____
7.	Have you ever had staff privileges at any hospital or health care facility that were ever revoked, suspended, curtailed, restricted, limited, otherwise disciplined, or voluntarily surrendered under threat of restriction or disciplinary action?	____	____
8.	Have you ever applied for or held a state or federal controlled substance certificate that was ever denied, revoked, suspended, restricted, voluntarily surrendered or otherwise disciplined or surrendered under threat of restriction or disciplinary action?	____	____
9.	Have you ever been convicted (including a nolo contendere plea or guilty plea) of a felony or misdemeanor (other than a minor traffic offense) whether or not sentence was imposed or suspended?	____	____
10.	Have you ever been rejected or censured by a medical society?	____	____
11.	In relation to the performance of your professional services in any profession:		
	a. Have you ever had a final judgment rendered against you;	____	____
	b. Have you ever entered into any settlement of any legal action; or	____	____
	c. Are there any legal actions pending against you or to which you are a party?	____	____
12.	Are you currently under investigation by a licensing board?	____	____
13.	My name has been placed on the registry of persons who have abused, neglected or misappropriated the property of vulnerable individuals (Tennessee abuse registry or an abuse registry in another state).	____	____

APPLICANT: FILL OUT THE FOLLOWING AFFIDAVIT IN THE PRESENCE OF A NOTARY PUBLIC

AFFIDAVIT AND RELEASE

I, ______________________________________, D.O., of ___________________________________

(Applicant's Name) *(City)* *(State)*

being duly sworn and identified as the person referred to in this application, attest to the truth of each statement made in said application. I further swear that I have read and understand the law and the Rules and Regulations that were enclosed in the application packet and agree to abide by them in the practice of medicine in the State of Tennessee.

I HEREBY:

SIGNIFY my willingness to appear to answer such questions as the Board may find necessary, which may include a full Board interview.

RELEASE to the Board, its staff, and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safely practice medicine.

AUTHORIZE the Board, its staff, and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others, and other qualifications.

RELEASE from liability the Board, its staff, and all their representatives and any and all organizations that provide information for their acts performed and statements made in good faith and without malice concerning my competence, ethics, character, and other qualifications for licensure.

ACKNOWLEDGE that I, as an applicant for licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical, other qualifications, and for resolving any doubts about such qualifications.

AUTHORIZE release, use and disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary.

THIS CERTIFIES THAT THE INFORMATION SUBMITTED BY ME IN THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

____ ________________________

SIGNATURE **DATE**

Sworn to before me this _________ day of ________________________, ___________.

____ Affix Seal Here

NOTARY PUBLIC

My Commission expires __________________________

SPONSORSHIP INFORMATION

THIS PORTION OF THE APPLICATION MUST BE COMPLETED BY THE DEAN OR PROGRAM DIRECTOR RESPONSIBLE FOR THE TRAINING PROGRAM

I, the undersigned, am submitting an application on behalf of ______________________________

(Applicant's Name)

to practice medicine in Tennessee with a special training license. **I am enclosing the following documents concerning this applicant with this application:**

1. An original medical school transcript sent directly from the applicant's medical school to me. (Note: the school's curriculum must be A.O.A. approved. The transcript must show that the degree was conferred and it must bear the institution's official seal.)

2. A clear and recognizable, recently taken photograph of the applicant that shows the full head, face forward from at least the top of the shoulders up.

3. Two (2) original letters from medical professionals on the signatory's letterhead attesting to the applicant's good moral character.

4. Proof of the applicant's United States or Canadian citizenship or evidence of being legally entitled to live and work in the United States or evidence of citizenship and residency in a N.A.F.T.A participating country. (Notarized copies of birth certificates, naturalization papers, current H-1 visa status, or voter registration are acceptable.)

5. A check or money order in the amount of Sixty Dollars ($60), payable to the Tennessee Board of Osteopathic Examination.

Tennessee licensed physician(s) who will have primary supervisory responsibility for the applicant:

Name and License Number: ______________________________

Name and License Number: ______________________________

Sponsoring Medical School: ______________________________

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____

____

DEAN'S OR PROGRAM DIRECTOR'S NAME AND TITLE:

____

(Please type or print)

SIGNATURE ______________________________ DATE ______________________

Please mail to:

Board of Osteopathic Examination
665 Mainstream Drive
Nashville, TN 37243